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ABSTRACT

Questions and answers are presented from an interview with a researcher on childhood mental illnesses. Dr. E. James Anthony responds to questions about such issues as the influence of parents on the development of child psychosis, the influence of age and ordinal position, advice about raising mentally healthy children, and the relationship between schizophrenia and achievement. (CL)

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National Institute of Mental Health

Q's & A's on Child Mental Health

An interview with Dr. E. James Anthony

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Q's and A's
on
CHILD MENTAL HEALTH

An interview
with
Dr. E. James Anthony

Dr. Anthony is director of the Harry Edison Child Development Research Center, Washington University, St. Louis, and receives financial support from the National Institute of Mental Health for research studies. He is a prominent investigator of the psychoses, behavioral disorders, and other mental illnesses of children.

In the following interview he responds to questions about:

- The influence of parents on the development of psychosis in children.
- Children who seem invulnerable to mental illness.
- The influence of age or ordinal position—in a family with a disturbed parent—on a child's mental health.
- Examples of children who break down.
- Advice on bringing up mentally healthy children.
- The relationship between schizophrenia and achievement.

The interviewer is Herbert Yahraes, who has long reported on mental health research.

Q: *How would you summarize your recent work, Dr. Anthony?*

A: For about 8 years now, we've been conducting research on the influence of parents on the development of disturbed behavior in the children. It is a longitudinal study; that is, we are following the families over a long period to see what happens. We are trying to learn if disturbed behavior in the parents is related to disturbed behavior in the children. At first we thought that there would be a simple correlation between the one and the other, but we are finding a far more complicated set of interactions.

Q: *What types of families are you working with?*

A: We chose to study three sets of parents; those who had a severe behavioral disorder, amounting to psychosis; those who had a physical disorder that affected their behavior—mainly tuberculosis; and those whom we regarded as being average normal parents—who had apparently no clinical disturbance.

We found that in any family where there was a severely disturbed parent, the children showed a wide spectrum of disturbances. Sometimes these were transient; sometimes permanent, seemingly; sometimes very severe; sometimes mild. Sometimes the child responded quite well—no disturbance whatsoever—and sometimes the child did even better than normal.

In some situations, it looked as if the children were simply reacting to the parent's disturbance. When the parent was hospitalized, or when the child was placed in a foster home during the period when the parent was acutely ill, the children seemed to settle down—in certain cases. On the other hand, if the child was suffering from a more inherent type of disorder—irrespective of whether he stayed or did not stay with the parent—he began to develop in a very insidious way a disturbance that was not unlike that of the parent.

Q: *Can you tell me about a case?*

A: The cases we see are mostly those that have been referred because things have started to go wrong in the family. It is difficult to talk about any particular one because, of course, these are all highly confidential. But some, disguised, have been reported upon in professional journals. For example, there was a 12-year-old girl who believed completely, along with her mother, that someone was poisoning the food at home. So, like her mother, she refused to eat except in a restaurant. Her younger sister, who was about 10, also refused to eat at home except when the father was there. When he was away, this girl, too, would go with her mother to a restaurant. But when I asked a 7-year-old brother why he was able to eat at home, he

shrugged his shoulders and said: "Well, I'm not dead yet!"

Q: *Was the mother suffering from paranoia?*

A: Yes. Schizophrenia—paranoid type.

Q: *What has happened to the children?*

A: The oldest girl eventually developed what seemed to be a psychosis like her mother's. The second child went to college and did quite well. The boy did brilliantly. He belonged to what we call the "invulnerables," who seem not only to be immune to pathological influences in the environment but almost to thrive on them.

Q: *What helped make him invulnerable?*

A: The mother's illness gave him a tremendous need to overcome obstacles, to deal with situations, to cope with problems. He seemed to see the environment as a sort of challenge. He had all sorts of good qualities. We were disturbed a little, it is true, about the price he seemed to be paying for his invulnerability; we wondered, it might be said, about his Achilles' heel. This is true with all the invulnerable children we have met. They all seem to pay a price. And the price they pay for invulnerability seems to be in terms of closeness of relationships. They develop a rather objective, dispassionate, distant relationship to people. This doesn't seem to be too abnormal, and it allows them to maintain their own integrity, to keep away from a disturbing influence. When they talk about, say, a sick parent, they do so with a sort of distant compassion. There is an objective, realistic quality about it; they seem less emotionally affected than the vulnerable children.

Q: *Does age or ordinal position in a family have anything to do with invulnerability?*

A: There is another type of disturbance where age and ordinal position are very important. Let me deal with that first, before coming back to the invulnerable child. This is the kind of trouble the French refer to as *folie à deux*, meaning that two members of a family have an almost identical disturbance. It's so close

it can look like a contagion. The child that becomes ill is likely to be—but is not always—of the same sex as the parent: If a mother was ill, a daughter would be more liable than a son to develop a similar illness. The process seems to be an exaggeration of the normal imitation and identification with the parent. The ordinal position is also important. Take a child who has younger siblings and is attempting to be the mother; the mother is sick, and this child is taking the mother's position. That child is more liable than the others to become sick. So one would say that the first-born child and the child of the same sex are especially prone to become ill, like the parent.

Q: *I suppose the mother and daughter you just talked about are an example. Is there another?*

A: Well, I have written about a 5-year-old boy who was addicted to TV cartoons. This boy began to worry that the world was going to be taken over by "Superguy," who could change himself into anyone or anything and was thus able to spy on people without their being aware of it. He could become a clock or a lamp and could send out messages by means of the ticking of the clock or the light waves of the lamp. There was no way of hiding from Superguy, since he could get in anywhere. The reason he focused on this particular home was that he knew it was the center of the whole world.

His mother had once worked as a secretary for a crime commission. Within the last year, she had begun to imagine that some of the criminals about whom she had typed reports were out to pay her back for the part she had played in getting them punished. There was a "Mister M.," who had been a much wanted man and "devilishly clever." They had been unable to catch him because he disguised himself so well. Every car that drew up on the street and every passerby was associated with "Mister M." At the sight of a strange face, she would immediately dial for the police. Her husband tried to obtain evidence from all quarters indicating that she had nothing to fear and that "Mister

M." was largely a figment of her imagination. But his wife persisted in her belief, and the character became increasingly bizarre. She began to refer to him as the gangster king and claimed that he had magical powers that allowed him to outwit the police and the F.B.I. He also used electronic listening devices, and she became suspicious of any article in the house that could be tampered with for this purpose. She stopped all the clocks in the house as a special precaution. She sat by one of the windows all day with the blinds drawn while her son kept watch near her. Her husband called in neighbors, and eventually doctors, to no avail.

Mother and son now appeared to have a common persecutor whom they both referred to as "Super" because he had such superior powers. They would not be separated from each other and paid little or no attention to the father. At last, much against his will, he had his wife hospitalized. The boy was at first panic-stricken, but, with the loving care of his kindly paternal grandmother, he soon settled down and gradually ceased to talk about "Super." The mother's diagnosis at the hospital was paranoid schizophrenia.

Q: *An interesting example. Thank you. Now, getting back to the invulnerable children—*

A: One can never predict beforehand which ones they are going to be. But they soon show themselves very clearly as being children who have an extraordinary degree of immunity to what's happening in the family. In our research, the true invulnerables have usually been boys. With regard to either sick mothers or fathers, girls seemed to identify more closely with a sick mother and to assimiliate more of her "sick" characteristics than boys.

The child who's destined to become sick is sometimes recognized by those closest to him. It's difficult at times to say whether this child is being scapegoated or whether a sort of self-fulfilling prophecy is being worked out. Very early we find parents, grandpar-

ents, uncles, aunts, saying, "just like his mother" or "poor fellow, his father was like that, too," and any behavior is immediately interpreted in a negative sense. We think that there is a certain sort of almost psychological inheritance going on. One of the English writers has referred to it as the ghost—the ghost in the genealogical tree, as it were, that haunts some particular member.

Q: *In your longitudinal research, what stage would you say you had reached?*

A: After 8 years of following up these children, we are beginning to see the first breakdowns. We have been watching more than 400 children. Close to half of these are in the experimental group, which comprises the approximately 50 families where there is a psychotic parent. In two-thirds of these families, the sick parent has been diagnosed as schizophrenic; in the other one-third, as manic depressive.

Q: *And the controls?*

A: We have two groups of these. One group comprises families in which one parent is tubercular; the other is made up of families in which both parents are presumably well—physically and psychologically. But in these supposedly healthy families we are finding more psychological problems than we had bargained for; perhaps that's because the families were volunteers.

Q: *Where are the breakdowns occurring?*

A: There have been six so far and they have all occurred in the index or experimental group—the families in which one parent is psychotic.

Q: *Do you find trouble arising among some of the controls?*

A: Among the children with physically ill parents, we've had quite severe emotional problems but no breakdowns. These children have been subjected not only to the illness of the parents but also, in some cases, to their death. And the loss of the parent has created certain emotional problems for the child.

Q: *Have breakdowns occurred among children who were being treated?*

A: Yes, in some cases. Let me explain. We tested each child thoroughly when he entered our research project. He was then anywhere from 1 to 17 years old. Through various psychological tests and psychiatric interviews, we think we can detect vulnerability in a child before it becomes manifested in difficult or inappropriate behavior. Then we sort of tag that child and monitor his further development. We say to ourselves: "This child is highly vulnerable, so we are watching him." And, often, we try to institute treatment or what might more accurately be called "preventive intervention."

So there are two outcomes. One is a test outcome, and the other is an actual clinical outcome. In the test outcome, we find in general that the interventions we have made have helped to reduce the apparent vulnerability of the child—sometimes a lot, sometimes only a little. The amount we've been able to reduce it depends somewhat on the cooperation of the family, on whether the family will, in fact, help and continue the good work that we start.

In these six cases, 50 percent broke down in spite of our intervention. We try to explain this by saying that the conditions surrounding the patient were such that the child really had no option except to break down. We feel justified in saying this because when we have intervened after one assessment of the child, the tests given at the next assessment show that the level of vulnerability has indeed been reduced. But whether or not it has been permanently reduced, we don't know.

Q: *I was under the impression that a child was said to be vulnerable because he or she was the son or daughter of a schizophrenic parent. Have I got that wrong?*

A: I often explain this by talking about three dolls. Each of these dolls is made of a different substance. One is

made of glass, one is made of plastic, and one is made of steel. Then someone comes along with a hammer and hits each doll on the head with the same force of blow. The first doll—the glass doll—just fragments, breaks up. The second doll, made of plastic, is dented—one might say scarred—for life. And the third doll just gives off a nice metallic sound—bang! —for it is made of steel. What we say is that the element of risk is the hammer. It is what is imposed on the child. We speak of children at high risk because they have a psychotic parent. Then, also, the psychotic parent provides a psychotic environment—a bad environment, a crazy environment to live in.

The element of vulnerability, on the other hand, is whether the child is genetically, or constitutionally, or environmentally made of glass, or steel, or plastic. If he is made of glass, even the slightest blow will break him up. If he is made of steel, the hardest blow won't damage him.

Q: *An example would be that family where the mother thought someone was poisoning the food?*

A: Yes. There were three children and three different reactions. One child became completely identified with the mother's delusion and was just as frightened as the mother. Another child was tempered by the presence of the father and behaved normally when he was around. The third child seemed completely unaffected. They had the same exposure, but the vulnerability was different.

Q: *You haven't figured out just why?*

A: We don't know what the glassiness or the steeliness or the plasticity represents in human terms. But when we test them in psychological terms they are different, so our psychological measures may relate in some way to glassiness—we don't know. One good thing we have learned, however: It is only among the very highly vulnerable ones that our breakdowns occur.

Q: *Do things like the complications of pregnancy and birth have anything to do with vulnerability?*

A: Yes.

Q: *I'm confused because I see it argued both ways. Some authorities say that the complications do have a lot to do with it and some say, "Well, it's not nearly so much as we thought. . . ."*

A: I think the complications are a factor. We do what we call a "risk assessment" of the child. We attempt to assess the amount of risk the child has been exposed to. We ask questions like: "Has he been exposed to a bad environment? Has he been separated from his parents? Has he been ill? Is he the first baby or second baby? Was there damage during the course of birth? Did he have an early infection?" We give each factor a weighting and eventually come up with a total risk assessment.

If we find that a state of susceptibility has been created, the question becomes whether or not we can change it through treatment. Until recently, there has been no other work like this—there has been nothing to go on. But a number of investigators are now using our methods.

Q: *In your paper, "Children at Risk From Divorce," I was surprised to find that there are relatively fewer children from divorced parents who turn out bad than other children.*

A: Well, when they turn out bad, they turn out really bad. It's again the question of risk. In our total experience of all children who have been exposed to disagreeable or bad conditions, we find that some tend to fall apart, but the majority tend to handle the situation quite well, and some, as I said before, seem to thrive on it. I've found many children of divorced parents who do extremely well, who are pushed into all sorts of special activities and develop abilities which they otherwise might not have had.

Q: *This is part of your own study?*

A: Yes, we have a small study, a substudy, going on on

divorce. We are really looking at all the possible problems that might confront the child in the world. For example, we've started now on the alcoholic parent. We know that alcoholic parents create alcoholic children, and we're much interested to learn how the process works—whether it is just simple exposure to the milieu or whether there is a factor, possibly a personality factor, that is inherited.

Q: *What do you know about the effect of the parents' personalities, anxieties, hangups?*

A: It is often said that neurosis—including overconcern with the ordinary anxieties of life and the ordinary depressions—tends to be passed on. But it is difficult to separate psychological from genetic inheritance because psychological inheritance starts so early in life. You know, right at the beginning, the anxiety of the parents begins to affect the child and makes him sensitive to anxiety. So it is very difficult to separate the two. There is no doubt, however, that neurotic parents seem to produce neurotic children. A large number of the childdren we see in our clinic have parents who need treatment also. The children come to us and then, after we see the children, the parents go into treatment, or at least we recommend that they do so.

Q: *When something goes wrong in a child, what can it be?*

A: A whole universe of things.

Q: *Is it possible to pick out two or three that are most important?*

A: I would say that without a reasonably good parent the child already has a strike against him. I would say that a good mothering experience right away, in early life, is about the most effective way of staving off some of the environmental and developmental hazards. You know, it's very hard to even treat a child who hasn't experienced a good early mothering relationship. That is because the child doesn't even know how to relate to another person. We take him

into treatment and he is almost unable to make any contact. And unless you make a contact with the child, a sort of friendly relationship, he is very difficult to treat. This is practically the key to both the diagnosis and to the treatment—the first supportive, encompassing relationship of the child with a reasonably good mother. Then, even if he gets ill later on, you can treat him because he already knows how to relate.

I always tell my psychiatric residents that when they find a child they can treat, they should get down on their knees and thank the parents who were able to give them a treatable child. This is a very important factor—right at the beginning of life—that the child know how to relate. So even if the parents make mistakes later on, or something else happens, the child is treatable. It's the untreatable child, or the child who is unreachable by ordinary methods, that is the great problem. The psychiatrist really needs that primary base—the child's ability to relate to other people. Without it, the therapist has to fall back on drugs, or try behavior modification, or something else that doesn't depend at the start upon the interaction between two people.

Q: *You might try behavior modification in a case like that?*

A: Yes. We have people here, working with severely disturbed children, who continue to try to make that relationship. They seem to be effective, but there's always a ceiling. It seems that when that primary experience in life—that early establishment of a good relationship with the mother or someone else—has been missed, you can only go so far in rehabilitating the child. You can get him to the point where he is fairly reasonable—where he doesn't disturb the law, for example—but not much beyond.

Q: *Somebody has said that the child and the mother make a contact very early—in the first few weeks or few months of life—that determines their relationship the rest of their lives. Do you go along with that?*

A: Yes. I would say that's true. It doesn't have to be the mother; it could be anybody who really gives the baby care. If you watch infants and you see the care that a good mother gives, you realize that she keeps the baby in a sort of little nest or little egg until the child is able to go by itself.

Today there is a lot of research on infants going on, which the Government is sponsoring because it realizes how important this is. And the researchers are finding that babies, from almost the first weeks of life, show different personalities, different constitutions, different rates of development. They are also finding that the way in which the parent helps the child to deal with problems from very early on—the way in which the mother steps in and helps the child to cope with the ordinary little beginning difficulties —becomes a sort of paradigm or example that the child carries in his head of how to deal with life later on.

Q: *Do you know a mental health researcher named John Bowlby?*

A: Very well. He's retired now, but he's made a huge impact on the world because he was the one who first suggested that the attachment behavior of mother and infant was necessary. He said that the infant needed his mother very early in life and that without attachment you got the most depressing things happening.

Q: *He said something to the effect that the baby imprints his relationship with his mother.*

A: Yes. He takes a sort of ethological point of view.

Q: *Do you go along with that?*

A: It's difficult to prove any sort of ethological principle in humans, but—well, there is the matter of the smile. Look at what the baby responds to, very early in life. You can put two dots in front of the baby's eyes. If the two dots are one above the other, he doesn't smile; if the two dots are side by side, he smiles. So obviously there is a smiling response, which

is a social response in relation to certain configurations of the human face. This suggests that early attachment behavior may indeed be based on some sort of ethological mechanism.

Q: *In line with what you've been saying, the trouble of the untreatable child may go all the way back to the first weeks of life?*

A: Yes.

Q: *To the failure to establish a good relationship with the mother or the caretaker?*

A: Yes. I would say the first *year* of life, because so much is done in that first year by the mother. The child really gets his expectations of the world then from the way people treat him. If he has a completely rejecting mother—if she won't have anything to do with him or she batters him or she treats him badly in other ways—it makes it absolutely impossible for that child to relate to people later. It seems to have become stocked deep in his mind that this is the way the world is—a battering, dreadful, brutal world that doesn't want him.

Q: *Suppose a parent or a prospective parent said to you: "What can I do to bring up my new child in such a way that he will not become mentally ill or emotionally ill? Are there some things I can do?" What might you tell them?*

A: I tend to think that a great deal should be left to the children and to foster the idea that it is up to them and that they must be the masters of their own fate. We, the parents, will always be around when the children really need us, but the really hard battles—they need to be fought alone. This may sound like a tough philosophy for childrearing, but we are talking about producing a relatively invulnerable child to live in a relatively tough world. And we have to find ways of toughening him but at the same time preserving his normal characteristics. In some instances we may be doing too much and in others too little.

Q: *Did you see a recent news story about an anthropologist at the University of Pennsylvania? In view of the widespread occurrence of schizophrenia, he said he was convinced that at one time, up until very recently, schizophrenia furthered the course of evolution. This was, he said, because when there were great changes in the society, schizophrenics may have helped the people to cope with them after traditional methods had failed. You saw that?*

A: Yes.

Q: *Does it make any sense?*

A: Let me tell you of a genealogical study in Iceland that covered almost 250 years—seven generations. Schizophrenia was first encountered in a woman born in 1735 and it was found in each generation after hers. Usually it had been transmitted through nonpsychotic members of the kindred. Many eminent persons had had this woman as an ancestor. Among them were writers, political leaders, and artists. One percent of the descendants were found to have been schizophrenic; on the other hand, 5 percent were described as superphrenic. The superphrenic is defined as a healthy person who has produced a psychotic child and is known to have had a psychotic parent or a psychotic sibling. He himself is altogether more gifted than the ordinary person.

It has been suggested that a schizophrenic is really a creative person with a less than normal ego capacity —or what might be called adaptive capacity or psychological strength. He has some novel way of looking at the world perhaps; he may have an extremely original mind. But he does not have the strength to carry his mind. So he breaks down and becomes unrealistic. His twin, as it were, the person on the other side of the line, becomes the creative artist, or the writer, and so forth. This suggests that madness and genius are related, you see.

Q: *Was Joan of Arc schizophrenic?*

A: With her hallucinations you mean? She was hearing sounds.

Q: *The anthropologist seemed to say she was schizophrenic.*

A: Yes. Well, for example, in work done at Berkeley, California, on creativity, it was found that if you took certain creative people and scored them on the Minnesota Multiphasic Personality Inventory (MMPI), they showed very great ego strength. They were excellent people, they were achievers. If you took people with the same rating for creativity but with weak ego strength, they were the sick people, the unhealthy people. The results suggest that perhaps the two aspects—the illness and the achievement—may be related much more closely than we usually think.

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